

7010

CERTIFICATE OF DEATH

Reg. Dist. No.

06983

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Chestertown				c. LENGTH OF STAY IN 1b 10 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) Quaker Neck Landing				d. STREET ADDRESS Quaker Neck Landing			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ellen Constable Beck				4. DATE OF DEATH June 3 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 23, 1900	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chestertown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Walker Beck				14. MOTHER'S MAIDEN NAME Mary Page Beck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 060094539			
17. INFORMANT Mrs. C.F. Foster, Chestertown, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary infarct Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Coronary artery disease (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 65 minutes 15 years 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-4 , 19 59 , to 6-3 , 19 60 , that I last saw the deceased alive on 5-30 , 19 60 , and that death occurred at 3:55pm , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Chestertown, Maryland DATE SIGNED 6-3-60			
ACTUAL SIGNATURE A.C. Dick				M.D. Chestertown, Maryland			
PHYSICIAN'S NAME (Type) A.C. Dick							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/6/60		22c. NAME OF CEMETERY OR CREMATORY St Paul Cem.		22d. LOCATION (City, town, or county) (State) RFD Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JUN 7 '60	
24b. REGISTRAR'S SIGNATURE William L. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1010

CENTRAL

1010

1010

1010

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

10 years (new) character

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06384

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton Rural			c. LENGTH OF STAY IN 1b lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton RFD		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD Butlertown				d. STREET ADDRESS Butlertown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle James Last Butler-III				4. DATE OF DEATH Month June Day 28 , Year 1960			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1947		9. AGE (In years last birthday) 12 yrs.	IF UNDER 1 YEAR Months 12 Days 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) school boy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME David James Butler Jr.				14. MOTHER'S MAIDEN NAME Pansy Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Pansy W. Butler Address Worton Md. RFD Butlertown			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929-8 DUE TO Was wading across creek and stepped in a hole which Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) was over his head. He was not able to swim. Body was DUE TO found approximately an hour after he stepped in hole (c) 							INTERVAL BETWEEN ONSET AND DEATH none
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) creek					
20c. TIME OF INJURY Month, Day, Year 4:-- 6/29/ 60 Hav. p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) creek		20f. (City or town) (County) (State) Worton(rural) Kent Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Robert W. Farr</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert W. Farr				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 2, 1960		22c. NAME OF CEMETERY OR CREMATORY Butlertown Cem.	
				22d. LOCATION (City, town, or county) (State) RFD Worton Worton, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth Waller</i>				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR JUN 30 60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form 10-1-58

2011

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. RACE [Illegible]	
5. DATE OF BIRTH [Illegible]		6. PLACE OF BIRTH [Illegible]	
7. DATE OF DEATH [Illegible]		8. TIME OF DEATH [Illegible]	
9. PLACE OF DEATH [Illegible]		10. OCCUPATION [Illegible]	
11. MARITAL STATUS [Illegible]		12. EDUCATION [Illegible]	
13. PRESENT ADDRESS [Illegible]		14. HOME PHONE [Illegible]	
15. MOTHER'S NAME [Illegible]		16. FATHER'S NAME [Illegible]	
17. MOTHER'S ADDRESS [Illegible]		18. FATHER'S ADDRESS [Illegible]	
19. MOTHER'S PHONE [Illegible]		20. FATHER'S PHONE [Illegible]	
21. MOTHER'S OCCUPATION [Illegible]		22. FATHER'S OCCUPATION [Illegible]	
23. MOTHER'S EDUCATION [Illegible]		24. FATHER'S EDUCATION [Illegible]	
25. MOTHER'S MARITAL STATUS [Illegible]		26. FATHER'S MARITAL STATUS [Illegible]	
27. MOTHER'S DATE OF BIRTH [Illegible]		28. FATHER'S DATE OF BIRTH [Illegible]	
29. MOTHER'S PLACE OF BIRTH [Illegible]		30. FATHER'S PLACE OF BIRTH [Illegible]	
31. MOTHER'S OCCUPATION [Illegible]		32. FATHER'S OCCUPATION [Illegible]	
33. MOTHER'S EDUCATION [Illegible]		34. FATHER'S EDUCATION [Illegible]	
35. MOTHER'S MARITAL STATUS [Illegible]		36. FATHER'S MARITAL STATUS [Illegible]	
37. MOTHER'S DATE OF BIRTH [Illegible]		38. FATHER'S DATE OF BIRTH [Illegible]	
39. MOTHER'S PLACE OF BIRTH [Illegible]		40. FATHER'S PLACE OF BIRTH [Illegible]	
41. MOTHER'S OCCUPATION [Illegible]		42. FATHER'S OCCUPATION [Illegible]	
43. MOTHER'S EDUCATION [Illegible]		44. FATHER'S EDUCATION [Illegible]	
45. MOTHER'S MARITAL STATUS [Illegible]		46. FATHER'S MARITAL STATUS [Illegible]	
47. MOTHER'S DATE OF BIRTH [Illegible]		48. FATHER'S DATE OF BIRTH [Illegible]	
49. MOTHER'S PLACE OF BIRTH [Illegible]		50. FATHER'S PLACE OF BIRTH [Illegible]	
51. MOTHER'S OCCUPATION [Illegible]		52. FATHER'S OCCUPATION [Illegible]	
53. MOTHER'S EDUCATION [Illegible]		54. FATHER'S EDUCATION [Illegible]	
55. MOTHER'S MARITAL STATUS [Illegible]		56. FATHER'S MARITAL STATUS [Illegible]	
57. MOTHER'S DATE OF BIRTH [Illegible]		58. FATHER'S DATE OF BIRTH [Illegible]	
59. MOTHER'S PLACE OF BIRTH [Illegible]		60. FATHER'S PLACE OF BIRTH [Illegible]	
61. MOTHER'S OCCUPATION [Illegible]		62. FATHER'S OCCUPATION [Illegible]	
63. MOTHER'S EDUCATION [Illegible]		64. FATHER'S EDUCATION [Illegible]	
65. MOTHER'S MARITAL STATUS [Illegible]		66. FATHER'S MARITAL STATUS [Illegible]	
67. MOTHER'S DATE OF BIRTH [Illegible]		68. FATHER'S DATE OF BIRTH [Illegible]	
69. MOTHER'S PLACE OF BIRTH [Illegible]		70. FATHER'S PLACE OF BIRTH [Illegible]	
71. MOTHER'S OCCUPATION [Illegible]		72. FATHER'S OCCUPATION [Illegible]	
73. MOTHER'S EDUCATION [Illegible]		74. FATHER'S EDUCATION [Illegible]	
75. MOTHER'S MARITAL STATUS [Illegible]		76. FATHER'S MARITAL STATUS [Illegible]	
77. MOTHER'S DATE OF BIRTH [Illegible]		78. FATHER'S DATE OF BIRTH [Illegible]	
79. MOTHER'S PLACE OF BIRTH [Illegible]		80. FATHER'S PLACE OF BIRTH [Illegible]	
81. MOTHER'S OCCUPATION [Illegible]		82. FATHER'S OCCUPATION [Illegible]	
83. MOTHER'S EDUCATION [Illegible]		84. FATHER'S EDUCATION [Illegible]	
85. MOTHER'S MARITAL STATUS [Illegible]		86. FATHER'S MARITAL STATUS [Illegible]	
87. MOTHER'S DATE OF BIRTH [Illegible]		88. FATHER'S DATE OF BIRTH [Illegible]	
89. MOTHER'S PLACE OF BIRTH [Illegible]		90. FATHER'S PLACE OF BIRTH [Illegible]	
91. MOTHER'S OCCUPATION [Illegible]		92. FATHER'S OCCUPATION [Illegible]	
93. MOTHER'S EDUCATION [Illegible]		94. FATHER'S EDUCATION [Illegible]	
95. MOTHER'S MARITAL STATUS [Illegible]		96. FATHER'S MARITAL STATUS [Illegible]	
97. MOTHER'S DATE OF BIRTH [Illegible]		98. FATHER'S DATE OF BIRTH [Illegible]	
99. MOTHER'S PLACE OF BIRTH [Illegible]		100. FATHER'S PLACE OF BIRTH [Illegible]	

1

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7003

CERTIFICATE OF DEATH

Reg. Dist. No.

06985

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 13 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes (3 weeks)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Herbert Last Elzey		4. DATE OF DEATH Month June Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1917
9. AGE (In years lost birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Lumber yard	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Herbert P Elzey		14. MOTHER'S MAIDEN NAME Louise Whaland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW2		16. SOCIAL SECURITY NO. 217-10-3819	
17. INFORMANT Hospital Records, Chestertown Md.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 weeks
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 25 , 19 60 , to June 16 , 19 60 , that I last saw the deceased alive on June 16 , 19 60 , and that death occurred at 2:10 AM , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED June 16, 1960	
ACTUAL SIGNATURE Robert W. Farr	M.D. Chestertown, Md.
PHYSICIAN'S NAME (Type) Robert W. Farr	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/18/60	22c. NAME OF CEMETERY OR CREMATORY Allen Cemetery	22d. LOCATION (City, town, or county) (State) Allen- Wicomico Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR JUN 20 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Hines

CERTIFICATE OF DEATH

7000

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BIRTH	
19. DATE OF BIRTH		20. SEX OF BIRTH		21. AGE AT BIRTH	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH	
25. CAUSE OF DEATH		26. MANNER OF DEATH		27. PLACE OF BIRTH	
28. DATE OF BIRTH		29. SEX OF BIRTH		30. AGE AT BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH	
34. CAUSE OF DEATH		35. MANNER OF DEATH		36. PLACE OF BIRTH	
37. DATE OF BIRTH		38. SEX OF BIRTH		39. AGE AT BIRTH	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. SEX OF BIRTH		48. AGE AT BIRTH	
49. DATE OF DEATH		50. TIME OF DEATH		51. PLACE OF DEATH	
52. CAUSE OF DEATH		53. MANNER OF DEATH		54. PLACE OF BIRTH	
55. DATE OF BIRTH		56. SEX OF BIRTH		57. AGE AT BIRTH	
58. DATE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. CAUSE OF DEATH		62. MANNER OF DEATH		63. PLACE OF BIRTH	
64. DATE OF BIRTH		65. SEX OF BIRTH		66. AGE AT BIRTH	
67. DATE OF DEATH		68. TIME OF DEATH		69. PLACE OF DEATH	
70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF BIRTH	
73. DATE OF BIRTH		74. SEX OF BIRTH		75. AGE AT BIRTH	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. SEX OF BIRTH		84. AGE AT BIRTH	
85. DATE OF DEATH		86. TIME OF DEATH		87. PLACE OF DEATH	
88. CAUSE OF DEATH		89. MANNER OF DEATH		90. PLACE OF BIRTH	
91. DATE OF BIRTH		92. SEX OF BIRTH		93. AGE AT BIRTH	
94. DATE OF DEATH		95. TIME OF DEATH		96. PLACE OF DEATH	
97. CAUSE OF DEATH		98. MANNER OF DEATH		99. PLACE OF BIRTH	
100. DATE OF BIRTH		101. SEX OF BIRTH		102. AGE AT BIRTH	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. PLACE OF BIRTH
10. DATE OF BIRTH
11. SEX OF BIRTH
12. AGE AT BIRTH
13. DATE OF DEATH
14. TIME OF DEATH
15. PLACE OF DEATH
16. CAUSE OF DEATH
17. MANNER OF DEATH
18. PLACE OF BIRTH
19. DATE OF BIRTH
20. SEX OF BIRTH
21. AGE AT BIRTH
22. DATE OF DEATH
23. TIME OF DEATH
24. PLACE OF DEATH
25. CAUSE OF DEATH
26. MANNER OF DEATH
27. PLACE OF BIRTH
28. DATE OF BIRTH
29. SEX OF BIRTH
30. AGE AT BIRTH
31. DATE OF DEATH
32. TIME OF DEATH
33. PLACE OF DEATH
34. CAUSE OF DEATH
35. MANNER OF DEATH
36. PLACE OF BIRTH
37. DATE OF BIRTH
38. SEX OF BIRTH
39. AGE AT BIRTH
40. DATE OF DEATH
41. TIME OF DEATH
42. PLACE OF DEATH
43. CAUSE OF DEATH
44. MANNER OF DEATH
45. PLACE OF BIRTH
46. DATE OF BIRTH
47. SEX OF BIRTH
48. AGE AT BIRTH
49. DATE OF DEATH
50. TIME OF DEATH
51. PLACE OF DEATH
52. CAUSE OF DEATH
53. MANNER OF DEATH
54. PLACE OF BIRTH
55. DATE OF BIRTH
56. SEX OF BIRTH
57. AGE AT BIRTH
58. DATE OF DEATH
59. TIME OF DEATH
60. PLACE OF DEATH
61. CAUSE OF DEATH
62. MANNER OF DEATH
63. PLACE OF BIRTH
64. DATE OF BIRTH
65. SEX OF BIRTH
66. AGE AT BIRTH
67. DATE OF DEATH
68. TIME OF DEATH
69. PLACE OF DEATH
70. CAUSE OF DEATH
71. MANNER OF DEATH
72. PLACE OF BIRTH
73. DATE OF BIRTH
74. SEX OF BIRTH
75. AGE AT BIRTH
76. DATE OF DEATH
77. TIME OF DEATH
78. PLACE OF DEATH
79. CAUSE OF DEATH
80. MANNER OF DEATH
81. PLACE OF BIRTH
82. DATE OF BIRTH
83. SEX OF BIRTH
84. AGE AT BIRTH
85. DATE OF DEATH
86. TIME OF DEATH
87. PLACE OF DEATH
88. CAUSE OF DEATH
89. MANNER OF DEATH
90. PLACE OF BIRTH
91. DATE OF BIRTH
92. SEX OF BIRTH
93. AGE AT BIRTH
94. DATE OF DEATH
95. TIME OF DEATH
96. PLACE OF DEATH
97. CAUSE OF DEATH
98. MANNER OF DEATH
99. PLACE OF BIRTH
100. DATE OF BIRTH
101. SEX OF BIRTH
102. AGE AT BIRTH

7006

CERTIFICATE OF DEATH

Reg. Dist. No.

06986

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cannon St.		d. STREET ADDRESS Cannon St.	
3. NAME OF DECEASED (Type or print) Jane (Janie) Louise Jamar		4. DATE OF DEATH June 6, 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Clay Usilton		14. MOTHER'S MAIDEN NAME Mary K. Gears	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-28-3702	
17. INFORMANT Mrs. June Kemp		Address 403 Cannon St. Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Possible Pulmonary Embolism DUE TO Auricular Fibrillation known for a year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Arteriosclerosis DUE TO don't know		INTERVAL BETWEEN ONSET AND DEATH 30 - 40 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 19, 59 , to June 6, 60 , that I last saw the deceased alive on June 6, 60 , and that death occurred at 10:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		DATE SIGNED 6/7/60	
PHYSICIAN'S NAME (Type) Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9, 1960	
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR JUN 10 '60		24b. REGISTRAR'S SIGNATURE John E. Bland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14

1

100 - 40 min
100 - 40 min

possible tuberculosis
pulmonary tuberculosis
chronic pneumonia

100 - 40 min

100 - 40 min

100 - 40 min

100 - 40 min

100 - 40 min

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7012

Items 12, Film 6265 6-21-60 et

06987

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairlee - Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lathbury Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural Fairlee) - Chestertown P. O.	
f. STREET ADDRESS RFD		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lemuel Alonza Leager		4. DATE OF DEATH Month Day Year June 14, 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct/ 31, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Ret. Owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lemuel F. Leager		14. MOTHER'S MAIDEN NAME Mary E. Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Catherxine Leager		Address RFD Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Serility Senility 7014X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/20 19 60 to June 14 19 60 , that (I) (we) last saw the deceased alive on 6/14 19 60 and that death occurred at 10 AM , from the causes and on the date stated above.			
22a. SIGNATURE Eugene Kester		22b. DATE SIGNED 6/15/60	
22c. PHYSICIAN'S NAME (Type) Eugene Kester		22d. ADDRESS Rock Hall, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/16/60	
23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		23d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR June 17 '60	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Howard	

STANDARD AND CAPITAL

5015

(M)

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

M
X
I
6

7013

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 5115 Queensberry Avenue	
3. NAME OF DECEASED (Type or print) Samuel First Unger Middle McConkey Last		4. DATE OF DEATH June 26 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 13, 1904
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. McConkey		14. MOTHER'S MAIDEN NAME Hannah Mae Unger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212 09 4048	
17. INFORMANT Address Mrs. Wm. H. Everngam - 505 Dogwood Dr.		Glen Burnie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable coronary thrombosis 420-1 DUE TO Had been known to suffer from high blood pressure and heart trouble. Arrived at Hotel Rigbie, Betterton, Md. to spend the weekend. When he failed to appear for breakfast the hotel management found him lying on the floor of his room, with the door locked, at 9:45 AM, 6/26/60 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH short	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. CAUSE OF DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) The body showed no signs of antemortem injuries.	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 26, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/60	
22c. NAME OF CEMETERY OR CREMATORY Kriders Cem.		22d. LOCATION (City, town, or county) (State) Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 29 '60	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06989

Reg. Dist. No.

2014

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kennedyville</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Salem</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney's Point</u> <u>67X-3</u> d. STREET ADDRESS <u>74 E Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ANTHONY</u> Last <u>MULHERN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1966</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26 1906</u>		9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Industrial</u>		11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Thomas Mulhern</u>				14. MOTHER'S MAIDEN NAME <u>Lillian M. Donohue</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>146-09-2605</u>		17. INFORMANT Address <u>Carney's Point New Jersey</u> <u>John Thomas Mulhern son</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>short</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Robert W. Farr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>June 18, 1966</u>			
EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 22, 1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lawnside Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Woodstown N.J.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Elbow Millington Md.</u>						ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 21 '66</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1914

NOT STATE

HEALTH DEPT.

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Md.</u> b. COUNTY <u>Kent Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester town</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester town, 11 NAH</u> Snow Hill	
c. LENGTH OF STAY IN 1b <u>Lifetime</u>		d. STREET ADDRESS <u>204 Martin St</u> 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Francis</u> Last <u>Porter</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1960</u>
9. AGE (In years lost birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>19</u> Mins <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Roy Dodson Porter</u>	
14. MOTHER'S MAIDEN NAME <u>MARY Joanne Archer</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Fetal Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>At Birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-9-60</u> , 19 <u>60</u> , to <u>6-10-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-10-60</u> , 19 <u>60</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>CHESTERTOWN, MD.</u> DATE SIGNED <u>6-10-60</u>	
PHYSICIAN'S NAME (Type) <u>O. S. GULBRANDSEN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/11/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u> ADDRESS <u>Chestertown Md</u>		24a. REC'D BY REGISTRAR <u>JUN 13 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1907

19

19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7015

CERTIFICATE OF DEATH

06991

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Fairlee) Chestertown		c. LENGTH OF STAY IN 1b adult life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chestertown (RFD Fairlee)		d. STREET ADDRESS RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home RFD Chestertown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elmina Ross Price		4. DATE OF DEATH Month June Day 23 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1866
9. AGE (In years last birthday) yrs. 93		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kent CO. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Gibbson Ross		14. MOTHER'S MAIDEN NAME Elizabeth Marim	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Mrs. Ethel Gibbs		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular DUE TO (c) Arterio Sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1 - 1959 to June 23 - 1960 , that (I) (we) last saw the deceased alive on June 23 - 1960 , and that death occurred at 7:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Norbert C. Nitsch		22b. DATE SIGNED 6/24/60	
22c. PHYSICIAN'S NAME (Type) Norbert C. Nitsch		22d. ADDRESS Rock Hall, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/25/60	
23c. NAME OF CEMETERY OR CREMATORY Chestertown Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Walsh		25a. REC'D BY REGISTRAR DATE JUN 27 '60	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

1990

CERTIFICATE OF DEATH

2012



MAINTAIN
DISEASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 5 Film G264 6/15/60 iwk
7016
CERTIFICATE OF DEATH

06992

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		c. LENGTH OF STAY IN 1b Millington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private Home		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle P. Last Schelts		4. DATE OF DEATH Month June Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 6, 1874
9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John E. Clough		14. MOTHER'S MAIDEN NAME Ellen Everett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Bulie Schelts,		Address Rural Kennedyville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Insanction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis Heart disease DUE TO (c) Generalized Arterio sclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 years D.K.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/14/1959 19____, to 6/9/60 19____, that I last saw the deceased alive on 6/2/60 19____, and that death occurred at 3 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. H. Hamilton		ADDRESS (Street, city or town, state) Millington Md	
PHYSICIAN'S NAME (Type) H. H. HAMILTON		DATE SIGNED 6/10/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 11, 1960	
22c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery		22d. LOCATION (City, town, or county) (State) Sudlersville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hollows		ADDRESS Millington Md	
24a. REC'D BY REGISTRAR DATE JUN 13 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hous	

7017

CERTIFICATE OF DEATH

Reg. Dist. No. 66993

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall (Part time)		c. LENGTH OF STAY IN 1b 11 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (At summer home)		d. STREET ADDRESS 113 Gladstone Rd.	
3. NAME OF DECEASED (Type or print) Marguerite Leone Schnars		4. DATE OF DEATH Month 6 / Day 14 / Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Clearfield CO. Penna.	
11c. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George E. Morley		14. MOTHER'S MAIDEN NAME Esther Anne Lucas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Chas. Earle Schnars		Address 113 Gladstone Road Lansdowne, Penna.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/14/60 , 19 60 , to 6/15/60 , 19 60 , that I last saw the deceased alive on 6/14/60 , 19 60 , and that death occurred at 10:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 6/15/60			
ACTUAL SIGNATURE William M. Gatewood		M.D. Rock Hall, Md.	
PHYSICIAN'S NAME (Type) William M. Gatewood			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/17/60	22c. NAME OF CEMETERY OR CREMATORY White Marsh Mem. Park	22d. LOCATION (City, town, or county) (State) Prospectville, Penna
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR JUN 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7011

[Faint, illegible text and markings on a form, possibly a death certificate. The text is mirrored and difficult to read.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7003

Reg. Dist. No. 06994

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 37 Chestertown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne Hosp.		d. STREET ADDRESS Cross St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annebell Middle Starkey Last		4. DATE OF DEATH Jun 3, 1960 Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/14/87
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Delaware	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Isaac Trice		14. MOTHER'S MAIDEN NAME Grave Williamson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma 926.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Blow on head DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3/13/60 3/13/60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Aneurism of abdominal aorta		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Alleged to have been struck by husband 3/13/60	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 3/13 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Chestertown Kent Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		DATE SIGNED June 6, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/6/60	
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE JUN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

M

072

COPIES SENT

2

14

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7018

CERTIFICATE OF DEATH

Reg. Dist. No.

06995

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Her Home Millington		c. LENGTH OF STAY IN 1b Millington X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ethel Middle R. Last Stevens		4. DATE OF DEATH Month June Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Own Home	
13. BIRTHPLACE (State or foreign country) Md.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Frank Taylor		16. MOTHER'S MAIDEN NAME Georgeanna Dailey	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. None	
19. INFORMANT Miss, Anna Stevens,		Address Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO arteriosclerosis (b) Diabetes mellitus DUE TO Diabetes mellitus (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 weeks yes 4 years			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28, 1960 to June 24, 1960 that I last saw the deceased alive on June 24, 1960 and that death occurred at 9 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE GEZA KORALEWSKI		ADDRESS (Street, city or town, state) MILLINGTON, MD	
PHYSICIAN'S NAME (Type) GEZA KORALEWSKI		DATE SIGNED 6-26-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27, 1960	
22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery		22d. LOCATION (City, town, or county) (State) Millington, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hellows		ADDRESS Millington, Md.	
24a. REC'D BY REGISTRAR JUN 28 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1913

5

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
John William		Male		35		March 1, 1878		Boston, Mass.		Boston, Mass.		United States	
MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE	
None		None		None		None		None		None		None	
OCCUPATION		PROFESSION		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		REMARKS	
None		None		None		None		None		None		None	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
None		None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	
None		None		None		None		None		None		None	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7009

Item 9 Film Q264 6/15/60 iwk

06996

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital		d. STREET ADDRESS Edesville RFD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Betty Middle Catherine Last Tilghman		4. DATE OF DEATH Month June Day 6 Year 1960	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kent CO. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Murray		14. MOTHER'S MAIDEN NAME Lizzie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-20-5145	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis. DUE TO (c) Diabetes Mellitus.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Amputation left leg due to Gangrene.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5:25 1960, to 6:6 1960 that (I) (we) lost saw the deceased alive on 6:5 1960, and that death occurred at 5AM , from the causes and on the date stated above.			
22a. SIGNATURE G. T. Keefe, M.D.		22b. DATE SIGNED 6.6.60.	
22c. PHYSICIAN'S NAME (Type) A. T. KEEFE, JR. M.D.		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-9-60	
23c. NAME OF CEMETERY OR CREMATORY Sharptown Cem.		23d. LOCATION (City, town, or county) (State) Rock Hall, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walker		25a. REC'D BY REGISTRAR JUN 10 '60	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

1000

STANDARD ALUMINUM

1000

